EKSPRESI SENYUM UNTUK MENINGKATKAN HUBUNGAN INTERPERSONAL

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Manusia selain sebagai makhluk individual, juga dikenal sebagai makhluk sosial. Sebagai makhluk sosial manusia menggunakan waktu yang paling banyak untuk mengadakan kontak, berkomunikasi atau berhubungan dengan orang lain. Komunikasi ini dapat berupa verbal dan nonverbal. Komunikasi verbal dilakukan dengan bahasa, sedangkan komunikasi nonverbal dapat dilakukan dengan gerakan tubuh dan tangan, juga melalui ekspresi wajah.

Menurut Burgoon, Buller, dan Woodall (1989) setiap perilaku komunikatif membawa komponen nonverbal. Dalam percakapan tatap muka, presentasi di televisi misalnya, semua saluran nonverbal ikut berperan dalam menghasilkan komunikasi secara keseluruhan. Perilaku nonverbal terutama berfungsi membuka menit-menit pertama dalam berhubungan dengan orang lain. Sebelum seseorang mengatakan sesuatu, perilaku nonverbalnya memberikan informasi dan gambaran kepada orang lain serta memberikan kerangka untuk interpretasi apa yang dikatakan secara verbal. Sebagai contoh, apabila seseorang menunjukkan sesuatu dengan jari telunjuknya, maka meskipun orang tersebut belum mengatakan sesuatu tetapi orang lain akan mengetahui apa maksudnya.

Tulisan ini akan mengulas bagaimana pentingnya eksppresi senyum, sebagai salah satu bentuk komunikasi nonverbal dalam kehidupan sehari-hari.

EKSPRESI SENYUM

Dalam melakukan hubungan dengan orang lain, lebih dikenal dengan sebutan hubungan interpersonal, tersenyum sebagai ekspresi wajah positif merupakan isyarat nonverbal yang paling mudah dikenal. Senyum merupakan komponen gerakan wajah yang berhubungan dengan dan disebabkan oleh perasaan bahagia atau senang. Sesuatu yang membuat seseorang merasa senang dan bahagia akan menghasilkan senyuman, kecuali jika orang tersebut ingin menutupi atau menghambat timbulnya senyum (Kraut & Johnston, 1979).

Pernyataan tersebut searah dengan pembagian jenis senyum, yang dilakukan oleh Ekman dan Friesen. Ekman dan Friesen (dalam Ekman, dkk., 1988) membedakan antara senyuman yang dihayati (*felt smiles*) dan senyuman palsu (*false smiles*). Senyuman yang dihayati mencakup semua senyuman yang benar-benar dialami dan menunjukkan emosi positif. Senyuman palsu adalah senyuman yang dibuat dengan sengaja untuk meyakinkan orang lain

bahwa senyum yang diberikan berasal dari emosi positif, meskipun sebenarnya tidak. Selanjutnya Ekman dan Friesen membagi dua macam senyuman palsu, yaitu *phony smiles* dan *masking smiles*. Dalam *phony smiles*, tidak ada sesuatu yang dirasakan, tetapi usaha dibuat untuk menunjukkan seolah-olah perasaan positif dirasakan. Dalam *masking smiles*, emosi negatif yang kuat dirasakan dan usaha dibuat untuk menyembunyikan perasaan ini dengan menunjukkan perasaan positif.

Gambaran pembagian jenis senyum tersebut tampak dari penelitian Ekman dan kawan-kawan (1988), yang meneliti senyum ketika berbohong. Pada penelitian tersebut peneliti ingin melihat *felt smiles* dan *masking smiles*. Pertama kali subjek melihat film tentang pemandangan alam, yang didesain untuk memunculkan perasaan yang menyenangkan. Subjek diwawancara dan diminta untuk menggambarkan perasaan yang sesungguhnya setelah melihat film tersebut (wawancara jujur). Setelah itu subjek melihat film tentang amputasi dan luka bakar, dengan maksud muncul emosi yang tidak menyenangkan. Kemudian subjek diminta untuk menyembunyikan perasaan negatif yang muncul dan meyakinkan pewawancara bahwa mereka melihat film yang menyenangkan (wawancara tidak jujur). Hasil penelitian tersebut menunjukkan bahwa dalam kondisi wawancara yang berbeda, senyuman yang dihasilkan juga berbeda. Ekspresi bahagia yang dihayati (*felt happy smiles*) berkurang dan *masking smiles* bertambah, jika wawancara berubah dari wawancara jujur ke wawancara tidak jujur. Selain itu, senyum bahagia tidak menghilang selama usaha untuk berbohong, tetapi berkurang dan pada saat yang sama lebih banyak muncul *masking smiles*.

Bagaimana seseorang dapat mengetahui bahwa senyum orang lain adalah senyuman yang dihayati, yang tulus atau yang tidak tulus? Ekman dan Friesen memberikan gambaran,bahwa senyuman yang dihayati akan tampak apabila sudut bibir terangkat ke atas, sehingga tulang pipi juga terangkat. Selanjutnya jika pipi terangkat, maka akan terlihat kerutan-kerutan di sekitar mata. Pada *masking smiles*, sudut bibir membentuk senyum, disertai dengan gerakan-gerakan otot wajah lain, yang menunjukkan emosi negatif, misal mata terbelalak karena takut. Tentu saja, senyum yang paling diharapkan muncul dalam hubungan interpersonal adalah senyum yang dihayati.

ARTI SENYUM

Senyum mengandung bermacam-macam arti atau pesan. Penelitian Page (dalam Deutch, dkk., 1987) menemukan, bahwa dibanding dengan orang yang tidak tersenyum, orang yang tersenyum dianggap lebih berbahagia, lebih hangat, lebih riang, lebih sukses, lebih rileks, dan lebih sopan. Penelitian lain menunjukkan, bahwa orang yang tersenyum dipandang lebih suka mengalah (*submissive*) kepada orang lain (Henley; Keating, dkk., dalam Deutsch, dkk., 1987).

Selain itu, tersenyum juga merupakan isyarat keramahan (Sears, dkk., 1988). Pendapat Sears dan kawan-kawan ini juga sejalan dengan pendapat Hooff (dalam Kraut & Johnston, 1979), yang menyatakan bahwa senyuman seseorang berfungsi untuk menghindari permusuhan dan memelihara hubungan persahabatan. Bayangkan, pembaca mengantar seorang

anak kecil untuk memeriksakan gigi. Di dalam ruang periksa, seorang anak melihat alat-alat kedokteran gigi, seperti tempat duduk dengan bermacam-macam bur, belum diperiksapun sudah menunjukkan kecemasan. Apalagi bila disertai dengan ekspresi perawat atau dokter yang "tidak ramah". Oleh karena itu, salah satu upaya yang dapat dilakukan profesional di kalangan medis untuk mengurangi kecemasan pasien adalah dengan lebih memperhatikan ekspresi nonverbal mereka, misalnya dengan memberikan senyum. Bahkan bukan hanya dengan senyum, tetapi juga dengan humor. Penelitian Nevo dan Shapira (1988) menunjukkan, bahwa humor melalui isyarat verbal maupun nonverbal yang dilakukan oleh dokter gigi dapat mengurangi kecemasan anak yang datang di klinik mereka.

Hooff (dalam Kraut & Johnston, 1979) mengatakan, bahwa senyuman diharapkan paling sering muncul dalam interaksi tatap muka, khususnya jika ada intensi persahabatan atau jika ikatan sosial akan dibangun dan dipertahankan. Selanjutnya Hooff menyatakan bahwa senyum banyak digunakan dalam ekspresi simpati, memberikan keyakinan, atau ketenteraman.

Pernyataan Hooff pada kalimat terakhir di atas perlu disimak lebih lanjut, terutama berkaitan dengan profesi profesional dalam menghadapi klien. Penelitian LaCrosse (dalam Edinger & Patterson, 1983) menunjukkan, bahwa konselor yang menggunakan cara afiliatif (antara lain dengan tersenyum) dinilai lebih persuasif oleh subjek daripada apabila menggunakan cara tidak afiliatif (antara lain tidak tersenyum) dalam menghadapi klien. Menurut Strong dan kawan-kawan (dalam Edinger & Patterson, 1983), perilaku nonverbal mempunyai efek pada persepsi klien terhadap kehangatan konselor. Konselor yang aktif, antara lain ditunjukkan dengan mengekspresikan senyum dinilai lebih hangat, ramah, dan enerjik dibandingkan dengan konselor yang kurang menggunakan gerakan nonverbal. Namun, konselor yang terlalu aktif, yaitu mereka yang terlalu banyak melakukan gerakan dinilai kurang serius dan kurang dapat menguasai diri.

Ekman dan Friesen (1984) menyatakan, bahwa senyum dapat digunakan untuk membuat situasi yang menekan lebih menyenangkan; dengan tersenyum seseorang akan dapat menyebabkan orang lain juga tersenyum, karena sukar untuk tidak membalas senyum tersebut. Hal yang terakhir ini sesuai dengan teori Jorgenson (dalam Hinsz & Tomhave, 1991) yang menyatakan bahwa jika seseorang tersenyum, maka orang lain akan membalas dengan tersenyum pula. Pernyataan Jorgenson ini sesuai dengan hasil penelitian Hinsz dan Tomhave (1991), yang meminta sukarelawan penelitian untuk tersenyum kepada subjek penelitian. Hasil yang ada menunjukkan, bahwa jika seseorang tersenyum kepada orang lain, maka orang tersebut akan membalas dengan tersenyum pula.

Knapp dan Hall (1982) menyatakan bahwa jika seseorang tersenyum kepada orang lain, maka dalam diri orang yang diberi senyuman tersebut akan terjadi proses atribusional ("Saya baru saja tersenyum kepada A, saya harus benar-benar menyukainya"). Proses ini menyebabkan perubahan nyata dalam sikap seseorang terhadap orang yang tersenyum. Dapat dikatakan bahwa senyum merupakan *reinforcer* atau penguat positif yang dapat mempengaruhi perilaku seseorang. Sebagai contoh, penelitian menunjukkan bahwa senyum (dan lain ekspresi) orang dewasa akan mempengaruhi suasana hati bayi dan responnya

terhadap lingkungan (Capella dalam Knapp & Hall, 1982). Senyum juga mempengaruhi perilaku orang dewasa. Misal, menerima senyum dari orang asing atau orang yang belum dikenal akan membuat seseorang suka menolong orang asing lainnya (Solomon, dkk., dalam Knapp & Hall, 1982).

Senyum pada Pria dan Wanita

Kramer (dalam Hall, 1990) mencatat suatu stereotip pada wanita bahwa wanita lebih banyak tersenyum daripada pria. Broverman dan kawan-kawan (dalam Hall, 1990) juga menunjukkan bahwa ekspresivitas emosional yang tinggi merupakan elemen kunci dari stereotip wanita. Selain itu Hall (1990) menyatakan bahwa emosi lebih mudah dilihat dari wajah wanita daripada wajah pria. Hal ini menurut Hall mengandung implikasi bahwa wanita lebih ekspresif daripada pria.

Stereotip dan pernyataan di atas didukung hasil penelitian yang menunjukkan bahwa wanita lebih ekspresif (melalui ekspresi wajah) daripada pria (lihat Burgoon, dkk., 1989).

Senyum pada wanita hampir universal dan dihubungkan dengan peran wanita bahwa wanita diharapkan tampak menyenangkan (Hall, 1990). Hal ini tampak dari penelitian Haviland (dalam Burgoon, dkk., 1989), yang meminta sekelompok orang untuk mengidentifikasi jenis kelamin bayi melalui sejumlah foto. Ternyata bayi yang menunjukkan lebih banyak ekspresi wajah positif diidentifikasi sebagai wanita, dan sebaliknya bayi yang kurang menunjukkan ekspresi wajah positif diidentifikasi sebagai pria.

Menurut beberapa *feminist*, stereotip bahwa wanita lebih banyak tersenyum dibandingkan pria merupakan suatu hal yang kurang menguntungkan, karena posisi wanita akan tampak lemah dan tampak ingin menyenangkan orang lain (Henley dalam Knapp & Hall, 1982). Akan tetapi kekuatiran para *feminist* tersebut tidak terbukti, karena belum ada bukti bahwa senyum wanita disebabkan kelemahan posisi wanita dalam masyarakat. Bahkan dalam penelitian Halberstadt dan kawan-kawan (dalam Knapp & Hall, 1982) menunjukkan bahwa orang yang mempunyai status sosial rendah jarang mengekspresikan senyum.

Berkaitan dengan pernyataan Hall bahwa senyum pada wanita hampir universal, selanjutnya penting untuk membedakan senyum wanita sebagai upaya menenangkan diri atau senyum yang keluar dari perasaannya (*felt smiles* menurut Ekman dan Friesen), atau senyum karena kebiasaan.

LaFrance dan Mayo (dalam Burgoon, dkk., 1989) menyatakan bahwa bagi wanita senyum adalah fenomena interaksional, sedangkan senyum pada pria merupakan ekspresi emosi. Hal ini sesuai dengan hasil penelitian Bugental dan kawan-kawan (dalam Knapp & Hall, 1982) yang menemukan bahwa wanita cenderung tersenyum, meskipun kata-kata mereka tidak mengandung pesan bahagia, sedangkan pria akan tersenyum sesuai dengan pesan yang disampaikan. Dalam penelitian lain, Halberstadt dan kawan-kawan (dalam Knapp & Hall, 1982) menemukan hasil yang berlawanan dengan penelitian Bugental dan kawan-kawan.

Dari gambaran di atas, kajian tentang perbedaan senyum pada pria dan wanita tampaknya menarik untuk diperdebatkan dan diteliti oleh para ahli. Pernyataan maupun hasil penelitian yang menunjukkan bahwa wanita menggunakan senyum sebagai alat interaksi, sedangkan pria menunjukkan senyum sebagai ungkapan perasaan bahagia, ataupun sebaliknya wanita tersenyum karena bahagia, sedangkan pria tersenyum untuk memperlancar pergaulan, masih terbuka untuk dikaji dan diteliti lebih lanjut.

EKSPRESI SENYUM DALAM HUBUNGAN INTERPERSONAL

Dari gambaran tentang arti senyum dapat disimpulkan, bahwa ekspresi senyum akan dapat mempertahankan atau bahkan meningkatkan interaksi seseorang dengan orang lain atau meningkatkan hubungan interpersonal. Hal ini dikarenakan tersenyum merupakan isyarat keramahan, dapat menghindari permusuhan, membuat situasi yang menekan lebih menye-nangkan dan memelihara hubungan persahabatan. Tersenyum juga berarti ekspresi simpati, memberi keyakinan, atau ketenteraman. Orang yang tersenyum dianggap lebih berbahagia, lebih hangat, lebih sukses, dan lebih sopan. Dengan demikian seseorang akan lebih senang bergaul dengan orang yang suka tersenyum daripada dengan orang yang tidak suka tersenyum.

Di dalam melakukan interaksi dengan orang lain, ekspresi senyum-sebagai bagian dari ekspresi wajah biasanya tidak berdiri sendiri, tetapi disertai gerakan nonverbal lainnya. Misalnya tangan dan lengan, dapat digunakan untuk mengatur dan memperlancar interaksi yang terjadi.

Kadang-kadang dalam melakukan hubungan tersebut terjadi isyarat nonverbal yang tidak jelas, ambigus, bahkan tidak jujur, kontradiksi dengan isyarat verbal (lihat kembali penelitian Ekman dkk. di atas). Meskipun sebagian besar orang menggangap bahwa ketidak jujuran merupakan suatu hal yang patut dicela dan tidak bermoral, tetapi berbohong adalah strategi komunikasi yang biasa dilakukan (Bok; Zuckerman, dkk., dalam Burgoon, dkk., 1989).

Ketika isyarat nonverbal berlawanan dengan isyarat verbal, apa sebenarnya yang terjadi? Menurut Ekman (dalam Knapp & Hall, 1982), mereka yang melakukan hal tersebut sebenarnya tidak ingin menceritakan kebenaran, sekaligus tidak ingin berbohong. Akibatnya mereka akan frustrasi, terjadi ambivalensi, selanjutnya akan menghasilkan isyarat nonverbal-verbal yang berbeda. Dalam situasi yang lain, pesan yang kontradiktif tersebut terjadi karena orang melakukan usaha berbohong, tetapi tidak sempurna. Selanjutnya Ekman mengatakan bahwa pesan kontradiktif dapat muncul sebagai hasil usaha untuk menyampaikan kata-kata kasar, ejekan, tetapi berlawanan dengan isyarat nonverbal (misal senyum).

Ketika seseorang berbohong, biasanya akan terjadi ketidak seimbangan psikologik karena ada perbedaan antara apa yang diekspresikan dengan apa yang senyatanya. Ekman dan Friesen, juga Zuckerman dan kawan-kawan (dalam Burgoon, dkk., 1989) menyatakan bahwa ketika orang tidak jujur, mereka mengalami reaksi internal, pada umumnya negatif,

Research paradigm

Mostly studies investigating the effect of culture on mental disorder exclude variables other than cultural variables. Physical settings of the society and genetic factors are among those that were frequently excluded. As has been found in some studies these variables are related to the occurrence of mental disorder. The effects of sunshine, weather, lunar position on mental disorder incidence have been found by a number of studies (for review see Moos, 1976). Genetic factors and its influence on mental disorder have also been demonstrated (for review see Hurst, 1965). Due to the facts that these variables are influential, then, in any cross cultural study of mental disorder these variables should be included. Heller and Monahan (1976) discussed the need to change the orientation regarding the etiology of mental disorder from a single-cause orientation to a multi-risk-factor orientation. The suggestion proposed by Heller and Monahan can also be applied to cultural study of mental disorder. This approach is expected also to give solution to the controversy regarding the role of genetic and environmental factors on mental disorder.

The second feature of cross-cultural study of mental disorder is cross-sectional. this paradigm can not detect the causes of change in incidence rate of mental disorder in a particular culture. For example, Kiev (1969) reported that in 1934, 111 cases of 'imu' (exotic disorder) were found among 17.500 Ainu in Japan. In 1958, in this same area; anly one case was found. This type of phenomenon can only be understood if there is a follow up study. Due to the facts that other variables (e.g. sunshine, weather, lunar position) have effects on the incidence of mental disorder, then a longitudinal study is a better paradigm. In addition, using a longitudinal paradigm, the effects of cultural change can also be assessed. This feature will enable us to detect the development of mental disorder, such as knowing the effect of social mobility on mental disorder.

CULTURE AS ETIOLOGY OF MENTAL DISORDER

In examining the effects of culture on etiology, two different issues attract our attention. First, in what way culture can be etiological factor, and the second, what cultural variables can be categorized as etiological factors.

Why culture can be etiological factor

The answer to this question may be seen from several theoretical, perspective. Psychoanalytic approach may see some aspects of culture as a source of stress and frustration, since they control the demand of primitive impulses. In the language of psychoanalytic theory, culture is the Super-ego which inhibits any demand which is socially unacceptable from the Id. If stress and frustration accumulate to a degree that can not be tolerated by the individual, then mental disorder symptoms develop.

From learning-theory perspective, culture can be etiological factor because culture provide channel for reinforcing the abnormal behavior. Kiev (1969) argued that a certain symptom

of mental disorder develop, because this symptom is rewarded in that particular culture. For example, in Haitian culture there is a kind of ritual activity that lead to trance accompanied by a reduction of higher integrative functions such as articulate speech, social inhibition, and muscular coordination, increase of reflex behavior such as trembling, convulsive movement, muscle twitching and teeth grinding. These behaviors are tolerated and applauded in ceremonies. Those eccentric behavior are culturally recognized and accepted ways of going crazy.

What cultural variables can be etilogical factor

Wittkower and Dubreuil (1964) speculated that there are three broad variables that can be considered as etiological factors : cultural contents refers to all beliefs, values, norms, attitudes, and customs in a people's culture. Social organization is the network of regular and relatively long standing interactions between members of society. Sociocultural change is any change in the cultural content and social organization. Wittkower and Dubreuil did not provide enough evidence to support the speculations made by Wittkower and Dubreuil. In interpreting the research findings, precautious actions should be taken. First, the findings may have artifacts, e.g. the data were not based on true prevalence, the diagnostic technique may not be appropriate for the society under study. Second, the relationship between cultural variables and mental disorder may be mediated by the third variable.

Cultural contents

- *Taboos*. A taboo is an act that is banned in any particular society. Taboos may relate to some basic need (e.g. food, drink), psychological need (e.g. sex, aggression, personal initiative, political and religious need). Lewin (1958) reported that in the culture where women are burdened excessive load of taboos, mental disorders in women tend to be more common.

Social organization

The lack of integration of social organization may create a favorable condition for development of mental disorder. Social disorganization such as unemployment, poverty, and racial conflict have been found to be related to prevalence of mental disorder. One of early studies on social organization was conducted by Hollingshed and Redlich (1953). Based on the data from the treated cases of mental disorder, they found that social economic status was correlated with the incidence of mental disorder. Individuals of low -social-economic status were more likely to be mental patients than individuals of high economic status. The data presented by Hollingshed and Redlich were based on treated case, not true prevalence. From this study we do not know whether people who do not come for psychiatric treatment will have the same tendency. A similar and more extensive study has been conducted in order to know whether there is correlation between social economic status and mental disorder in people who do not go for psychiatric treatment.(Schwab, Bell,

Warheit, & Schwab, 1979). Using a number of dependent measures (a.g. interview, personality inventories) they found the pattern of findings that is similar to the findings of Hollingshed and Redlich. People of low social economic status were more likely categorized as having psychiatric problems.

Although the data regarding the relationship of social economic status and mental disorder is rather consistent , the real cause of this relationship is not clear. To what degree the difference in community tolerance and social economic status have influence on psychiatric diagnose. Similarly to what extent the downward social mobility, or cumulative stress experienced by lower economic status individuals would be the causes of mental disorder. These questions need to be answered in future studies.

Sociocultural change

It is hypothesized that cultural change may increase the incidence of mental disorder (Wallace, 1969). Even though this hypothesis is appealing, however there were only few studies attempted to test it. Probably the reason for the lack of interest in studying the effects of cultural change is that the study needs time to detect the change. The effects of cultural change can not be detected in a short time period.

The first study aimed at investigating the effect of cultural change on mental disorder was conducted by Goldhamer and Marhall (1953). Using the hospital admission record in Massachusetts area between 1840 - 1940, they found that in 100 year period, the rate of functional psychoses remains constant, despite the culture has changed. Several explanation for this findings has been proposed. One explanation argued that there was a possibility that people of 1940 were more tolerant to mental disorder, so the mentally disorder was not always sent to hospital. Second, Massachusetts was an industrial area which had been so advanced in technology in 1840, the 100 year lapse did not influence any change in sociocultural aspects.

If the attention is directed to the effects of sociocultural change in societies where the change is a process of acculturation of the traditional culture, one could find the support for the hypothesis that cultural changes cause mental disorder incidence increased. Shore, Kinzie, Hampson, and Pattison (1973) reported, based on their study on Indian villages, that the occurrence of mental disorder among younger Indians who had been exposed to "white culture" was significantly higher than the older Indian who still preserved the traditional culture. A rather similar phenomenon was also reported by Beaglehole (1969) in reviewing studies on mental disorder among New-Zealanders. Due to acculturation process, the native-born Maoris showed a higher rate of mental disorder, as compared to the Maoris of previous culturated generation. Interestingly this study showed that the sociocultural changes among Maoris produced changes in pattern of disorder. It was reported that between 1953-1957 about 46.9% of Maoris admitted to mental hospital were diagnosed as manic-depressive, and only 23.4 were classified as schizophrenic. With the acculturation process, the pattern of disorder changed dramatically few years later. The data on mental

hospital admissions between 1958 - 1960 incated that the number of schizophrenic cases among Maoris increased to 40.9%, while manic-depressive decreased to 17.5%. However the data did not allow us to know for sure whether this change in pattern was due to the cultural changes or due to changes in criteria of diagnosis.

IMPACTS OF CULTURE ON CLINICAL SYMPTOM

Discussion on this section will be focused on the way cultural factors are related to common mental disorder (e.g. schizophrenia, manic depressive), and culture-bound syndrome. Which specific cultural factors that cause disorders remains unknown. There have been some speculations about the possible cultural factors that lead to different symptoms. However, there is no supporting data for these speculations. So they will be excluded from discussion.

Common mental disorder

Sanua (1969) reviewed hundreds of studies focusing on impacts of cultural factors on clinical symptoms of schizophrenia. One conclusion from the review is that schizophrenia is found in all cultures, and its symptomatology is colored by the culture. Some of the studies reviewed showed that schizophrenia in primitive African societies is quiter than in the Western countries. Among Indian schizophrenics, catatonic, body rigidity and negativism were reported to be very common. Asiatic schizophrenics were said to be more with drawn and less aggressive, while the southern Italian patients showed the reverse of Asiatic symptoms.

Manic-depressive psychosis has been intensively investigated. Murphy, Wittkower, and Chance (1964) reported that symptoms of endogenous depression, mood change during the day, insomnia, diminution of interest in social environment, were commonly found among Europeans. In non European countries the pattern of depression is different from European. Where it is rarely found the feelings of guilt, of self accusation, and of punishment as the ones frequently found in European countries.

With regard to psycho neuroses, some evidences showed that acute anxiety reactions of short duration are more common in primitive societies than in advanced societies (Murphy et.al, 1964). Social economic status, and race also found to be correlated with symptomatology of psychoneuroses. Black Americans showed a higher level of anxiety, depression, and phobia than the white Americans (Schwab, Bell, Warheit & Schwab, 1979).

Culture-bound syndrome

Yap (cited from Leighton, 1969) divided culture-bound syndromes into three types of symptomatology, fear reactions, rage reactions, and dissociation states. Discussion on each type will be presented below.

Fear reactions.

"Latah" refers to a kind of disorder where a patient at the beginning of attack repeat their own words and sentences, then those of others, especially person in authority. Later on patients repeat words and sentences of other surrounding him. At other times the patient do the opposite what the others do. The precipitating factor of the attacks is the word snake, or by tickling. This kind of disorder occurs in Indonesia and Malaysia. A rather similar type is called "imu", the symptomatology is similar but the precipitating factor is the sight of snake. "Imu" is a disorder that frequently happen in Japan.

"Koro" is another culture-bound syndrome that mostly occurs in South East Asian countries. The patient of "koro" experiences a severe anxiety due to being afraid that his penis will with draw into his abdomen.

"Susto" or "magic fright" is a kind of syndrome that has been reported among Central and South American Indian tribes. The Symptoms are intense anxiety, hyper excitability, generalized phobias, depression and somatic symptoms.

Rage reactions

"Amok" is a rage reaction syndrome that was found in Indonesia, Malaysia and Philippines. The patients of "amok" attack almost everything surrounding him. This is a male-type disorder.

Dissociation states

Trance and possession are examples of dissociation-states-mental disorder. The persons who see the patients on attack believe that the spirit of outside agencies such as animal, ancestors, ghost has intruded the patients. The symptom of this disorder are empty face, change in tone of voice, change in manner of speaking, and staring into space. This disorder found in Haiti, Philippines and Indonesia.

CULTURE AS DETERMINANTS OF INTERVENTION

There have been a number of criticism addressed to western oriented intervention techniques. For example Cohen (cited in Lebra, 1976) observed that in making diagnosis and treatment, there a remarkable lack of direct attention to ethnicity, race, and cultural identity. Lack of attention and consideration to these cultural aspects have led the intervention into failures. Yamamoto et.al (Heller, 1981) reported, for example, therapists tend to conduct treatment in accordance with the value system of the middle class. This approach has proven ineffective with and discouraging to lower-class patient. A number of therapists became frustrated because patients did not respond well to this approach. Therapists discouraged patients from seeking continued therapy after the first meeting. In responding to the demand for solution, a new intervention techniques been developed.

Christmast, Wallace and Edwards (1973) suggested that utilizing the indigenous therapists seem to solve the problem. Indigenous therapist can communicate well with the patients probably due to the similarity of cultural background. Another attempt of intervention has also been developed. A sociologically based intervention suggest to provide opportunities to achieve success (e.g. education, jobs) for the lower social economic status persons. This success will eliminate disorders. In support to this claim Odell (1974) did a study on the effects of providing education and jobs on the incidence of delinquency. The findings of his study showed that by providing the education and the jobs delinquency rates reduced tremendously.

Another cultural factor that may be important determinant for intervention is belief about the cause of mental disorder. It has been reported in several studies (Lebra, 1976) people in developing countries tended to attribute the cause of mental disorder to unnatural factors such as magic power, spirit possession or ghost. This same phenomenon also has been reported to be existed in the modern country. Wintrob (Heller, 1981) reviewed studies dealing with the belief system of ethnic minorities within the United States in relation to the causes and appropriate treatment of mental disorder. The findings revealed that there are two principal causes of disorder, natural and unnatural. Natural causes are factors such as genetic predisposition, nutritional imbalance or infection, parental abuse, or stress of poverty. Unnatural causes are spirit possession or malign magic. It was also reported by Wintrob (Heller, 1981) that there is a growing interest among "white-subgroups" about faith-healing, spirit possession or mediumship as an effort to undertand mental illness. Different beliefs regarding the causes of disorder may determine the choice of mental treatment. Research findings reported by Wintrob showed that people who believe that the causes of disorder are unnatural factors tend to recommend to use community healers (spiritist, curers) more frequently than hospitals or doctors.

This finding suggests that belief system can be used as a guide line of intervention. For example, It is a waste of money and time to build community-mental-health centers in the area where people believe that community healers are the best source of help for mental disorder. The present writer is not aware of any study aims to compare the effectiveness of community healers as compared to modern therapists in curing mental disorder in the area where people believe in unnatural forces as the causes of disorder. Certainly it will be a good idea to demonstrate this effectiveness for the purpose of designing mental health service.

The last cultural factor that warrants attention is the pattern of social relationship among people in a particular society. This pattern of social relations may determines the success of intervention. Yamamoto (Heller, 1981) criticized the way American psychiatrist treated patients of Asian origin. Criticisms were addressed on two areas. First, American evaluation of patients is too often a one-dimensional focus on the individual. This way of evaluation neglects the importance of close family ties in Asian culture. Secondly the role that frequently played by therapists is neutral, non jugmental and non critical toward patients. This role is alien to Asian countries. The family unit is headed by the patriarch in Asian

countries. In contrast to American egalitarian values, the relationship are vertical. This vertical family relationship between therapist and patient requires the therapist to be an authority figure. The above criticism suggest that in order to have a better intervention, a more accurate culturally based diagnosis should be matched with culturally sensitive treatments.

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